INSTRUCTIONS

COMPLETING EMPLOYEE FIRST REPORT OF INJURY

1. Employee or an individual acting on the employee's behalf completes the Employee First Report of Injury Form.

2. Supervisor or another responsible administrative official completes the Supervisor's Report of Injury and WorkPro Form.

3. **INJURED EMPLOYEES SHOULD BE SEEN ON A WALK-IN BASIS WITHIN 3 WORKING DAYS OF THE ACCIDENT IN ANY WORKPRO OCCUPATIONAL HEALTH OR OCCUPATIONAL MEDICAL SERVICES (OMS) LOCATIONS OR YOUR TREATING PROVIDER. THE EMPLOYEE MAY CARRY OR THE PERSONNEL OFFICE MAY FAX THE REFERRAL FORM TO THE MEDICAL CENTER.**

NOTE:

THE COMPLETED FIRST REPORT OF INJURY PACKET SHOULD BE GIVEN TO MICOLE VENNIE IN THE OFFICE OF HUMAN RESOURCES WITHIN 3 WORKING DAYS AFTER THE INJURY OCCURS. THE INFORMATION MAY BE EMAILED TO MICOLE AT MICOLE.VENNIE@MARYLAND.GOV. FAILURE TO PROVIDE THE PROPER DOCUMENTATION WITHIN THE ESTABLISHED TIME FRAME COULD RESULT IN A DELAY OR DISAPPROVAL OF ACCIDENT LEAVE. FOR ANY ADDITIONAL QUESTIONS, PLEASE CONTACT MICOLE VENNIE AT 410-767-5532.

Employee's Report of Injury

(To be completed by the employee only.)

Employee's name: _____ Male__Female__
Last First Middle

Date of birth: __ / __ / __ Home telephone # (_____) _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Present classification: _____ How long employed here: _____

Social Security No.: _____ - _____ - _____ Weekly salary:

Location of accident: _____
Address Area (loading dock, bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

Describe bodily injury sustained (be specific about body part(s) affected):

Recommendation on how to prevent this accident from recurring: _____

Name of supervisor: _____ _____ _____ Phone# _____
Last First

Name(s) of witness(es): _____ Phone# _____
(Attach witness(es) report(s))

When did you report the accident to your supervisor? _____

To whom did you report the injury? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____

Name of your treating physician: _____ Phone# _____

Signature of employee: _____ Date: _____

Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible administrative official)

Location where accident occurred	Employer's Premises: ☐ Yes ☐ No Job site: ☐ Yes ☐ No		Date of accident or illness
Who was injured?	☐ Employee ☐ Non-Employee		Time of accident a.m. or p.m.
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred? Property/equipment owned by:
What property/equipment was damaged?			
What was employee doing when injury/illness occurred?	What machine or tool was being used?	What type of operation?	
How did injury/illness occur? List all objects and substances involved.			
Part of body affected/injured?	Any prior physical conditions? If so, what? ☐ Yes ☐ No		
Nature and extent of injury/illness and property damaged (be specific)			

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

__ Failure to lockout	__ Failure to secure	__ Horseplay
__ Improper dress	__ Improper guarding	__ Improper instruction
__ Improper maintenance	__ Improper protective equipment	__ Inoperative safety device
__ Lack of training or skill	__ Operating without authority	__ Physical or mental impairment
__ Poor housekeeping	__ Poor ventilation	__ Unsafe arrangement or process
__ Unsafe equipment	__ Unsafe position	__ Other _____

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? _____ Yes _ No __

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? _____ Yes _ No __

Did employee promptly report the injury/illness? _____ Yes _ No __

Is there modified duty available? _____ Yes _ No __

_____

Supervisor's name | Supervisor's signature | Phone# | Date

IWIF • 8722 Loch Raven Boulevard, Towson, MD 21286-2235 • www.iwif.com
Form may be copied as needed

Accident Witness Statement

(To be completed by accident witness)

Injured employee's name: _____
Last First Middle

Name of witness: _____ Ph# _____
Last First Middle

Job title of witness: _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____ _____
Address/Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

_____

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected):

_____

_____

_____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

Name of Witness's Supervisor: _____ Ph# _____
Last First

Signature of Witness: _____ Date: _____

204B 01/03

WORKPRO OCCUPATIONAL HEALTH

PIVOT OCCUPATIONAL HEALTH

OMS OCCUPATIONAL MEDICAL SERVICES Your Partner in Employee Health

State of Maryland

Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)

Agency:_____ **Today's Date:**_____

(List Agency or Sub-Agency to Receive Invoice) **Appointment Date/Time/Location** (if applicable):

_____

Agency Location:_____ **Authorized By:**_____

Agency Phone No.:_____ **Agency Fax No:**_____

Employee:_____ **Employee Date of Birth:**_____

Please check all that apply:

☑ **Work Injury/Illness** Date of Injury_____ Claim# (if available) _____

Physical Examination

☐ Pre-placement ☐ Pre-placement w/ Ergonomic Assessment ☐ DOT– Regulated (Recert ONLY)

☐ Fitness for Duty/Ability to Work ☐ Medical Surveillance ☐ FAA - MDOT

☐ Initial Workability ☐ Follow-up Workability ☐Other: _____

Substance Abuse Testing

☐ DOT - Regulated Drug Test ☐ Non-regulated Drug Test *(a.k.a. MDOT Drug Test)*

☐ DOT – Regulated Alcohol (Breath) ☐ Non-regulated Alcohol Test (Saliva) *(a.k.a. MDOT Alcohol Test)*

☐ Other: _____ ☐ Direct Observation Required

Reason for Substance Abuse Testing

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-accident ☐ Random

☐ Follow-up ☐ Return to Duty ☐ Other _____

Psychological Services

Please Provide Employee/Applicant Phone # and Zip Code -AND- DAC's Email Address

☐ Psychological Testing (Psych Eval) ☐ SAP ☐ Critical Incident Management

Other Services

☐ Respirator Fit Test ☐ Audiogram ☐ PPD ☐ Pulmonary Function Test ☐ EKG

☐ Chest X-ray ☐ Vaccinations:_____ ☐ Other:_____

Special instructions/comments_____

_____

For WORKPRO and PIVOT Occupational Health locations and hours, visit www.PivotOccHealth.com

WORKPRO Occupational Health Locations
&
Occupational Medical Services (OMS) Locations
Effective 4/1/17

Note: Contact Names, Numbers, Emails to follow.

WORKPRO Maryland

6785 Business Parkway, Suites 1&2
Elkridge, MD 21075
Hours: Mon – Fri 7:30am – 4:30pm

844 Washington Road, Unit 203
Westminster, MD 21157
Hours: Mon – Fri 7:30am – 4:30pm

2618 North Salisbury Blvd, Suite 130
Salisbury, MD 21801
Hours: Mon – Fri 7:30am – 4:30pm

Opening Date: 4/1/17

2875 Crain Highway
Route 301 South
Waldorf, MD 20601
Hours: Mon – Fri 7:30am – 4:30pm

14302 Barton Boulevard SW
Cumberland, MD 21502
Hours: Mon – Fri 7:30am – 4:30pm

WORKPRO Delaware

914 Justison Street
Shipyard Shops
Wilmington, DE 19801
Hours: Mon - Fri 7:30am – 5:00pm

4051 Ogletown-Stanton Road, Suite 102
Iron Hill Corporate Center, Sabre Wing
Newark, DE 19713
Hours: Mon - Fri 7:30am – 5:00pm

283 North DuPont Highway
Kohl's Center
Dover, DE 19901
Hours: Mon – Fri 7:30am – 4:30pm

543 North Shipley Street
Professional Building, Suite F
Seaford, DE 19973
Hours: Mon - Fri 7:30am – 4:30pm

503 W. Market Street, Suite 100
Nanticoke Immediate Care
Georgetown, DE 19947
Hours: Mon - Fri 7:30am – 4:30pm

OMS Locations

Arbutus
4807 Benson Avenue
Baltimore, MD 21227
Hours: Open 24 Hrs

Canton
3600 O'Donnell Street, Suite 170
Baltimore, MD 21224
Hours: Mon – Fri 7:30am – 5:00pm

Belcamp
1200 Brass Mill Road, Suite C
Belcamp, MD 21017
Hours: Mon – Fri 7:00am – 5:00pm

Greenbelt:
7933 Belle Point Drive,
Greenbelt, MD 20770
Hours: Mon – Fri 8:00am – 4:30pm

State of Maryland - WORKPRO & OMS

WORKPRO DE Sites

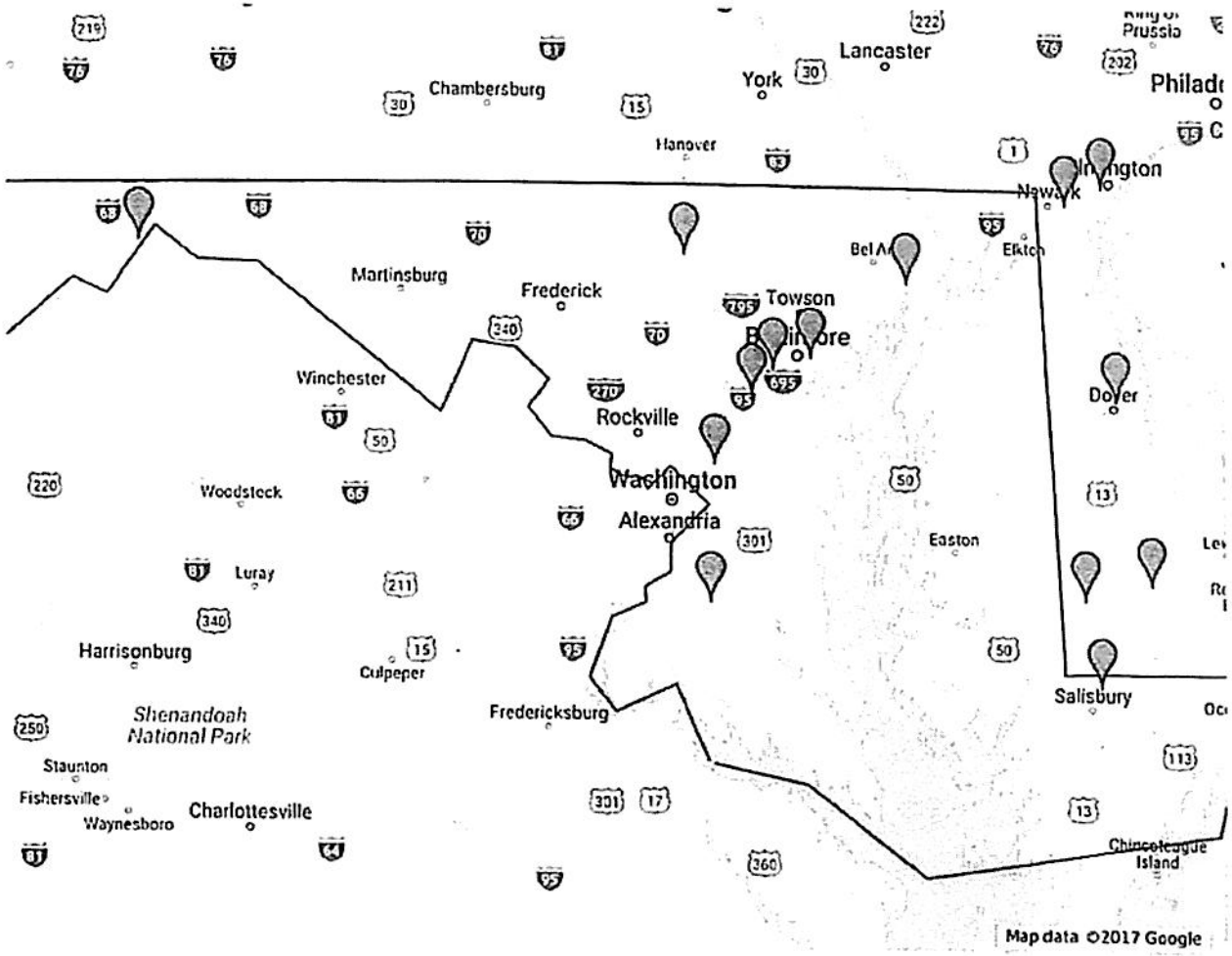
- WORKPRO, Wilmington DE
- WORKPRO, Newark DE
- WORKPRO, Dover DE
- WORKPRO, Georgetown DE
- WORKPRO Seaford DE

WORKPRO Maryland

- WORKPRO Westminster
- WORKPRO - Elkridge
- WORKPRO Waldorf
- WORKPRO Cumberland
- WORKPRO Salisbury

Occupational Medical Services

- OMS, B'More (Arbutus)
- OMS, B'More (Canton)
- OMS, Belcamp
- OMS, Greenbelt



REQUEST FOR SERVICES

INJURY CARE

Employee's Name _____ Social Security # _____

Date of Request _____ Date of Birth

Home Phone # _____ Work Phone # _____

Address _____

Occupation/Job Title _____

Scheduled Date of Exam _____ Time _____ Network Site _____

Authorized by _____ Agency Phone # _____

Agency _____ Agency Fax # _____

SERVICE REQUESTED:

__ Injury care Date of Incident: _____ Injury: _____

__ Injury Evaluation/Second Opinion/Periodic Injury Evaluation (P.I.E.)

The following should be forwarded to the center or accompany the patient to the center at time of appointment:

A. Employee's position description/job description
B. Must call in First Report of Injury for Work Injury/Illness to Injured Workers' Insurance Fund

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********** (Employee Section) **********

This will authorize the State Medical Director's Office to release all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated to my employer, the insurance carrier or the agents. This also authorizes The State Medical Director's Office to obtain all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated and/or treated.

Employee's Signature _____ Date _____

(OVER)

Provider Section

Diagnosis _____ Health Classification with respect to physical/mental requirements of the job:

1. _____Recommended/regular activities

2. _____Recommended pending ancillary testing

Health-related condition(s) exists which may interfere with performance of essential job functions:

Current Activity Status:

Lifting Limits (weight range and frequency) _____
Sitting (needs and limits) _____
Mobility Impairment (specify) _____
Vision/Hearing Impairment (specify) _____
Mental Health Needs _____
Travel (specify needs and limits) _____
Working Hours _____

4. _____ Deferred/pending - further evaluation by _____

5. _____Does not meet US DOT requirements/essential job functions

6. _____Other/ Comments

The above activity restrictions expire: _____

The above health classification was explained to patient: __ yes ___no

Employee's Signature _____ Date _____

Examining Professional (print) _____

Examining Professional's Signature _____ Date _____

This assessment was performed _ with __ without a written statement describing the essential functions of the job.

A copy of this form completed by the provider should be placed in a sealed envelope and returned to the designated agency contact.

Time In w/Initials _____ Time Out w/Initials _____